Frequently Asked Questions about Hospice Provider Notice 01-06
Medicaid Approval for Hospice Care-Update

1. **Question:** Should providers send information to the agency after the initial certification for hospice, i.e. for subsequent 90 day or 60 day periods?

   Answer: No, a provider should send information to the Medicaid Agency for an initial hospice election and if a patient will be on the program for six months or longer.

2. **Question:** If a provider has recipients that have been on the program longer than six months before February 1, 2006, should information for that patient be sent to the Medicaid Agency?

   Answer: The provider should send information to the Medicaid Agency if the recipient remains on the hospice program 6 months after the effective date of the policy change of February 1.

3. **Question:** This policy change has the potential for placing a burden on Medicaid Agency staff. Is there a possibility that providers will be able to process applications and approve the level of care?

   Answer: This a difficult question to answer at this time. The retrospective review process was very time intensive and the agency found many individuals were placed on the hospice program inappropriately. The inappropriate placements have placed a great administrative burden on the agency due to the time involved in determining and initiating recoupments and the fair hearing process. No changes to the Agencies new procedure is anticipated at this time.

4. **Question:** Should providers send information to Medicaid for dually eligible recipients in the nursing home?

   Answer: Providers should not send information to Medicaid for dually eligible recipients for initial hospice elections and recipients on the program 6 months or longer who are dually eligible.

5. **Question:** Should providers continue to use the Medicaid Hospice election form for dually eligible recipients?

   Answer: No, hospice providers can now use the Hospice Recipient Status Change Form to notify the agency of dates to be added to the LTC for dually eligible recipients upon initial admission, who are discharged from the nursing home to the hospital or from the nursing home to the community, expire or are readmitted to the nursing home from the hospital.

6. **Question:** What is the turn around time for application processing now that the LTC Admissions/Records Unit will review initial applications?

Answer: The Agency will have 30 days to process the application and the provider will be notified with an acceptance within 48 hours of completion of the review. Denials will be mailed to the provider within 48 hours.

7. **Question:** If a provider submits information on Feb 23rd and it takes 30 days to process the application, when will the provider have the ability to bill for reimbursement?

Answer: Once the provider is notified of a hospice care acceptance, the provider can bill for services rendered.

8. **Question:** If a provider is unable to obtain a physician's signature by the eighth day as required by Rule No. 560-X-51-.03 (3) will a faxed signature by the eight day be sufficient as long as an original signature is obtained with 30 days?

Answer: If every effort is made to secure written certification within eight calendar days and the hospice provider can not obtain the written verification; a physician signature obtained by fax will meet the certification requirement. Written certification must be secured and retained in the client record within 30 days of the hospice election.

9. **Question:** If a dually eligible patient leaves the NH and enters the hospital- should the provider send the Hospice Status Change Form to the Medicaid Agency since Medicare is paying for the hospice care and the agency only pays room and board? The hospice provider will not bill Medicaid for the room and board but pays the 4 day bed hold to the Nursing Home.

Answer: The hospice provider should send the Hospice Recipient Status Change form to the Medicaid Agency when any of changes addressed on the form for dually eligible recipients occur or contact agency staff with questions about other situations the provider may encounter. This form helps the agency to have valid data on file for room and board liability for these recipients.

10. **Question:** Are the benefit periods used by the Medicaid Agency for hospice changing?

Answer: No, the physician certification for two 90 day periods and subsequent 60 day periods remains the same.

11. **Question:** Since providers use the Hospice Recipient Status Change to report information to the Medicaid Agency for dually eligible recipients, can this

be sent by fax instead of regular mail?

Answer: The Hospice Recipient Status Change form can be sent to the LTC Admissions/Records Unit by fax at (334) 353-5901 since the form is only one page.

12. **Question:** After February 1 will providers still have the ability to verify eligibility?

Answer: Yes, providers will have the ability to verify eligibility. Chapter 3 Section 3.2 of the Medicaid Agency Provider Manual, on *Confirming Eligibility*, outlines various resources providers may use to verify recipient eligibility, i.e. Provider Electronic Solutions software, Automated Voice Response System, etc.

13. **Question:** Should the Hospice Program Cover Sheet be faxed to notify the LTC Admissions/Records Unit that patient records are on the way?

Answer: No. The hospice provider must send the patient records and Hospice Program Cover Sheet together by mail to the Admission/Records Unit.

14. **Question:** Should a provider start hospice services before the application is approved by Medicaid?

Answer: The decision to begin hospice services is the discretion of the provider. Providers must be sure the recipient meets Medicaid hospice criteria for admission before sending information to the Medicaid Agency. Providers may contact the Agency for assistance for diagnoses not found in the hospice criteria or for pediatric cases.

15. **Question:** There is space on the Hospice Recipient Status Change Form for hospice revocations. If the hospice provider is discharging a patient where should the information be documented?

Answer: The "reason for revocation" area on the form can be used to report this information. Please be sure to include the date of discharge.

16. **Question:** If a **hospice patient in the community** has coverage through Blue Cross Blue Shield as their primary insurance and Medicaid is secondary what information should be sent to the Medicaid Agency for this patient?

Answer: The Medicaid Agency does not need information for this patient as long as hospice is a covered service with the insurance carrier. If hospice is not a covered service, Medicaid would then be primary and all policies for Medicaid recipients would apply.

Question: What if this **patient was in a nursing facility** instead of the community-Blue Cross paying for patient care and Medicaid paying for room and board?

Answer: In this situation once the patient is admitted to the hospice program the hospice provider must submit the Hospice Recipient Status Change form to the Medicaid Agency indicating the recipient insurance with Blue Cross Blue Shield.